



MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: MEMORIAL HERMANN HOSPITAL SYSTEM 3200 SOUTHWEST FRWY SUITE 2200 HOUSTON TX 77027	MFDR Tracking #: M4-07-6046-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: TEXAS MUTUAL INSURANCE CO Box #: 54	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "It is the hospital's position that the hospitalization was an emergency as defined pursuant to the Acute Care Hospital Fee guideline. Texas Mutual issued an underpayment of \$9,495.96 as a fair and reasonable rate of reimbursement."

Request for Reconsideration Letter: "We are requesting that additional payment of \$14,070.93 (85% of billed charges) be issued..."

Amount in Dispute: \$18,229.79

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Medicare would pay the requestor \$6,116.32..." "Texas Mutual paid \$9,495.96, an amount more than fair and reasonable. The requestor, on the other hand, in support of its billing as fair and reasonable is that it expects 85% of its billing charges."

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
6/2/2006 through 6/5/2006	CAC-W10, CAC-97, 217, 426, 719, CAC-W1, CAC-143, CAC-18, 420, 480, 878	Inpatient Trauma Surgery Admission	\$18,229.79	\$0.00
Total Due:				\$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code § 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.1, titled *Medical Reimbursement*, effective May 2, 2006 set out the reimbursement guidelines.

This request for medical fee dispute resolution was received by the Division on May 16, 2007.

- For the services involved in this dispute, the respondent reduced or denied payment with reason codes:
 - CAC-W10-No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology.
 - CAC-97-Payment is included in the allowance for another service/procedure.
 - 217-The value of this procedure is included in the value of another procedure performed on this date.
 - 426-Reimbursed to fair and reasonable.
 - 719-Reimbursed at carrier's fair & reasonable; cost data unavailable for facility. Additional payment may be considered if data submitted.
 - CAC- W1-Workers Compensation state fee schedule adjustment.

- CAC-143-Portion of payment deferred.
 - CAC-18-Duplicate claim/service.
 - 420-Supplemental payment.
 - 480-Reimbursement based on the Acute Care Inpatient Hospital Fee Guideline per diem rate allowances.
 - 878-Duplicate appeal. Request medical dispute resolution through DWC for continued disagreement of original appeal decision.
2. The Respondent denied reimbursement based upon duplicate claim/service. The disputed service was a duplicate bill submitted for reconsideration of payment. The Respondent did not provide information/documentation of duplicate payments. Therefore, this payment denial reason has not been supported.
 3. This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.401(c)(5)(A), effective August 1, 1997, 22 TexReg 6264, which requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 824.8. The Division therefore determines that this inpatient admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).
 4. Division rule at 28 TAC §134.1, effective May 2, 2006, 31 TexReg 3561, requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
 5. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
 6. Division rule at 28 TAC §133.307(c)(2)(F)(iv), effective December 31, 2006, 31 TexReg 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include a position statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the requestor's documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of Division rule at 28 TAC §133.307(c)(2)(F)(iv).
 7. Division rule at 28 TAC §133.307(c)(2)(G), effective December 31, 2006, 31 TexReg 10314, applicable to disputes filed on or after January 15, 2007, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:
 - The requestor asks to be reimbursed the full amount of the billed charges in support of which the requestor states "It is the hospital's position that the hospitalization was an emergency as defined pursuant to the Acute Care Hospital Fee guideline. Texas Mutual issued an underpayment of \$9,495.96 as a fair and reasonable rate of reimbursement."
 - In the alternative, the requestor states in letter requesting reconsideration of payment that "We are requesting that additional payment of \$14,070.93 (85% of billed charges) be issued..."
 - The requestor does not discuss or explain how payment of 100% or 85% of billed charges would result in a fair and reasonable reimbursement.
 - The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
 - The Division has previously found that a reimbursement methodology based upon payment of a hospital's billed charges, or a percentage of billed charges, does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the *Acute Care Inpatient Hospital Fee Guideline* adoption preamble which states at 22 Texas Register 6276 (July 4, 1997) that:

"A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs,

would be administratively burdensome for the Commission and system participants, and would require additional Commission resources.”

- The requestor did not submit nationally recognized published studies, published Division medical dispute decisions, or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not discuss or explain how payment of the requested amount would satisfy the requirements of Division rule at 28 TAC §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

8. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307(c)(2)(F)(iv) and §133.307(c)(2)(G). The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code §133.307, §134.1, §134.401
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

_____	_____	01/21/2011
Authorized Signature	Medical Fee Dispute Resolution Officer	Date
_____	_____	01/21/2011
Authorized Signature	Medical Fee Dispute Resolution Manager	Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.